GLOBAL CONSULTATION ON MIGRANT HEALTH
National School of Public Health | Madrid, Spain | 3–5 March 2010

POLICY AND LEGAL FRAMEWORKS AFFECTING MIGRANTS’ HEALTH
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Policy and Legal Frameworks Affecting Migrants’ Health*

Overview

This chapter aims to provide an introduction to the existing policy and legal frameworks on or affecting migrants’ health. It also gives examples of practices. It argues that policies must span across sectors in order to adequately address the variety of situations in which migration can occur and the range of migrant health issues. The paper will first introduce the policy considerations raised by modern migration patterns and will then discuss three elements of past, current and developing policy: disease control, migration management and control, and legal norms. The paper will examine the responsibilities of states and stakeholders at each stage of the migration process and will provide recommendations for improving current practices. Finally, the paper will evaluate current concerted international efforts towards policy change.

Policy coherence across migration and health sectors presents numerous challenges. Traditional policies and regulations focus on disease control, emerging public health issues both globally and in the hosting community, and the cost implications of addressing migrant health needs. Others address issues of adaptation, integration, accessibility, acceptability and quality of health services for migrants and the human rights implication thereof. Policies tend to focus on immigrants rather than considering migration health beyond nationality and residence; they tend to focus on communicable diseases rather than lifestyle risk factors and preventive care. When focusing on migrant workers, policies and legislations may not adequately consider their dependents’ health. Conflicting pressures created by policies and regulations in areas such as security, registration, profiling, labour or criminalization of migration, migrants and health professionals are directly linked to migrant health.

Nationality or residence are frequently associated with elements of requirement or regulation, designed to control or balance the allocation of associated privileges or access to services. At the same time, population health policies and principles are based on fundamental concepts of universal access to preventive and clinical health and medical services, promotional, preventive or therapeutic. Unless they are addressed in a unified manner, these differences in approach can be counterproductive to overall national and global health goals.

The provision of health services to migrants who might not have routine access to them can produce beneficial outcomes. Access to care, particularly in terms of health promotion and disease prevention can reduce both the future demands for health care and also subsequent expenditures. Expedient access to therapeutic services can prevent the progression of disease to more advanced stages, which would require more expensive or involved treatment. Finally, in terms of public health, the early identification and mitigation of communicable diseases can significantly reduce subsequent costs and resource demands on health services.

Historically, with the exception of quarantine and infectious disease control elements, the health and immigration policies of many countries have developed independently. Based on traditional immigration patterns, it was frequently assumed that migrants who did not become permanent residents would reside only temporarily and then return to their normal place of residence. Those who were long-staying would acquire access to care as they formalized their residence.

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Modern migration, which can involve large numbers of irregular migrants who may reside for long periods without routine access to health services, has altered the historical patterns in several locations. Policy attempts to control or manage migration now have to be balanced with policies designed to improve health and mitigate the health effects of inequity.

Responding to the patterns of modern migration requires coordinated policy development processes that involve both the health sector and those responsible for immigration policy. In some countries, consultations of this nature may not be commonly undertaken. Migration can result in situations where the local health impact or event was generated or created beyond the national boundary or jurisdiction. And yet migrant health policies, by nature, have to be global in context. While national immigration sectors may be more familiar with managing the domestic consequences of international events and situations, this is a policy approach that will need to become more integrated into the national health sector in nations with large migrant populations. This level of coordination has challenges of its own.

Policy coherence in the context of health and migration also highlights the effects of global health disparities which, through migration, present at national level. Policies which ensure that migrants receive similar levels of care to those available for the host population will reduce some of the health disparities and limits to care faced by many migrant populations and communities. In a similar vein, some nations are coordinating cross-border aspects of health care to accommodate the growing impact of migration. Countries with shared borders or significant international migrant flows have enacted policies to ensure sustained treatment, epidemiological surveillance and, in some cases, payments for the care of migrants moving between them.

There is a parallel series of policy issues and needs related to migrant health associated with the economic aspects of health care delivery. Policies that ensure or recommend care need to be accompanied by fiscal policy elements to pay for the care. There are several models in use in this regard. Central health budgets may be used to provide care to migrant residents who have no access. In other locations, insurance or payment is provided to migrants who register or identify themselves as being in need.

Independent of the delivery model, there are several policy challenges associated with care delivery and its cost. Some services are necessary to facilitate access and utilization of health care, including transportation to providers, and the availability of culturally and linguistically competent health services. The costs and funding for ancillary migration health program elements of this type may extend beyond the health sector. In these situations, additional policy coordination is required between the migration/immigration sector and other national ministries or departments, civic municipalities and non-governmental organizations (NGOs).

Policies to improve health service provision to migrants should also aim to include the involvement of migrants and migrant communities to ensure program adequacy. The perspective provided by migrants, including their intimate understanding of the social, cultural, and linguistic aspects of health, is a necessary component of migration health policy development.

Policy coherence in migrant health has some implications that extend beyond national and regional borders. Aspects of what are considered essential, basic, routine or standard health care services differ between countries and regions according a complex series of economic, domestic, social and political factors. The nature and type of basic services provided by counties to their domestic populations differ, as do methods of obtaining and paying for essential and non-essential services. Sustained disparities in care that are tolerated at national level can assume significant policy importance in terms of migration when individuals or communities move from more advanced levels of care to locations where care is less prevalent or available.
Adequately dealing with the interface between health and migration that occurs at the global/national level requires additional international policy coordination and coherence. Global policies and strategies directed at reducing health disparities should incorporate the impact of current and future migration demographics. At the same time, health policies in countries with large numbers of migrants will need to encompass global elements to mitigate the impact of domestic health challenges that originate beyond national borders.

Migration policies, health policies, and other policies affecting migrant health can only be viable and effective when they are based on a firm foundation of legal norms, and thus operate under the rule of law. International standards set parameters for the respect of human rights, including the right to health and health related rights, for the protection of migrants, and for respect of the sovereign interests of states. National legislation and practice must therefore comply with international norms, which provide a continuous framework of protection from human rights violations.  

**Basic Elements of Migrant Health Policy and Legal Framework**

The following section will outline three key elements of policy and legal frameworks affecting migrants’ right to health: disease control, migration management and control, and norms.

**Disease Control Elements**

Policies, edicts and legislation designed to limit or mitigate the spread of infectious diseases represent some of the earliest recorded organized public health activities. Early religious texts in several cultures contain references to practices and procedures to be used to deal with travellers afflicted with certain feared diseases. The management of leprosy in medieval Europe is an example.

Faced with the threat of imported plague in the 14th century, regulatory processes were enacted to manage and control the arrival of goods and people from areas known or suspected to be disease affected. These processes of quarantine and isolation expanded globally in parallel with colonization, trade and migration. They were often driven by important international disease threats, such as cholera in 19th century and yellow fever and malaria in the 20th. They are distant progenitors of today’s International Health Regulations (IHR).

Today, globalization, high-speed travel and growing international migration are recognized as factors influencing the international spread of some diseases of public health importance. While rare in occurrence, the outcome can be significant. Migrants from vulnerable environments may be at greater population-based or epidemiological risk of acquiring some of the diseases of public health importance. As a consequence, and because regulatory processes continue to be applied to those crossing international borders, migrants may also be at increased likelihood of being subject to the application of disease control legislation. Fundamentally based on principles of protecting the majority, quarantine, some disease control policies, and legislation can interfere with or limit an individual’s rights. These components can include elements of voluntary and, in situations of lack of compliance, involuntary isolation or detention pending treatment or disease resolution. Ensuring that regulatory activities and policies meet the needs of migrants while avoiding discrimination is important for legal, humanitarian and public health reasons.
Migration Management and Control Elements

While quarantine practices could be applied to all travellers, some nations receiving large volumes of international pilgrims or migrants have introduced specific immigration-related medical activities for these populations. Some of those migrant-specific health policies exist at international levels, such as those currently defined in Article 31 (1) (b) of the IHR. More frequently, however, immigration-related health legislation is found at national level, since states have competency regarding, inter alia, the determination of nationality, admission, residence of non-nationals, security / border control measures and detention.

Migrant health policies vary in relation to the characteristics of the migrants themselves. For example, health status may be used to determine fitness for work or entry for migrant workers. For regular immigrants, the health status or condition at the time of application may be a component of immigration selection and acceptance criteria. In most cases, policies exist to waive such health related entry requirements for refugees and others in need of international protection, except in conditions where communicable disease concerns are identified.

As it will be explained in depth later, state authority over entry, stay, expulsion and detention is limited by international law and international human rights law in particular.

Norms

Human rights approach to health

Ensuring that human rights are fundamental components in the design, implementation and evaluation of health related policies and programmes provides the basis of a human rights approach to health. Furthermore, it guarantees that states are complying with their obligations under international human rights law and is often in line with their national Constitutions. Rights-based components include equality and non-discrimination, the active and informed participation of involved individuals and communities, a sustained focus on the most vulnerable and marginalized in society, and the existence and effectiveness of accountability mechanisms. The use of these normative standards and principles shapes both policy-making and action concerning health intervention at all levels. A human rights-based approach to programming would optimize a holistic and integrated process as well as health outcomes with a focus on the goals of health promotion and disease prevention.

The protection offered to migrants by International Law

Migrants are first of all human beings and hence right holders. states have to protect the human rights of migrants, including their right to health, regardless of their migration status.

There is, nevertheless, a disparity between the principles agreed to by governments and the reality of individual lives, which underscores the vulnerability of migrants in terms of dignity and human rights. Migrants may face discrimination on multiple grounds and are particularly vulnerable to human rights violations. Migrant workers are too often seen as exploitable and expendable, a source of cheap, docile and flexible labour, consigned to dirty, dangerous and degrading work or working conditions and at a high risk for being victims of occupational accidents. Irregular migrants, including irregular migrant workers, tend to belong to the most deprived sections of the population, and therefore their social protection deserves particular attention. Victims of trafficking in persons often suffer from a multitude of physical and psychological problems. Migrants are among the most vulnerable when sexual and reproductive health is analysed. Asylum seekers constitute a particularly vulnerable section of the population due to pre-migration risk factors such as torture or other trauma, which may result in physical and mental problems. However, some other migrants, usually skilled workers who move to take up professional jobs in the formal sector, may have relatively few human
rights problems. Focusing on those with the greatest needs is one of the challenges of policy development in migrant health. The report by the World Health Organization (WHO) Secretariat supports action in this regard by highlighting that many ‘migrants’ fundamental health needs are not always adequately met, thus raising concerns with regards to equity, social cohesion and inclusiveness.

Human rights law is central to migrants’ protection. Founded upon the inherent dignity and equal and inalienable rights of every human being, the principles of equality and non-discrimination lie at the heart of international human rights law. In accordance with these principles and the provisions set out in the core universal human rights instruments, states have an obligation to protect the human rights of all individuals within their territory, including migrants, regardless of their migration status. Thus, the human rights of migrants are protected under all the core international human rights treaties.

In addition, many of the rights applicable to migrants are part of customary law and must be observed by all states and guaranteed to all persons.

Finally, human rights law also operates in combination with different areas of international law that have implications for the right to health of migrants. Those other areas include aspects of labour, humanitarian and refugee law. For instance, the International Labour Organization (ILO) standards that make up international labour law are intertwined with human rights law and include specific reference to migrant workers. These standards cover occupational safety and health. The ILO has produced several instruments protecting the rights of all workers, including migrant workers, and four specific conventions and recommendations. Migrant workers benefit from both specific provisions of the ILO instruments related to migrant workers as well as all the core international human rights treaties.

**Health as a human right, human rights as migrants’ right, health as migrants’ right**

Health as a human right for all was first enunciated at international level by the Constitution of the WHO. It was then reiterated in the Universal Declaration of Human Rights, Article 25; and in several legally binding international human rights treaties, such as the International Covenant on Economic, Social and Cultural Rights, Article 12; the International Convention on the Elimination of All Forms of Racial Discrimination, Article 5; the Convention on the Rights of the Child, Articles 24; the Convention on the Elimination of All Forms of Discrimination against Women, Article 12; the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, Articles 28, 43 and 45; and the Convention on the Rights of Persons with Disabilities, Article 25.

The central formulation of the right to health is contained in Article 12 of the International Covenant on Economic, Social and Cultural Rights. Article 12.1 recognizes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”, which is abbreviated to the “right to health”. The scope and content of this specific right is based on general comment No. 14 of the Committee on Economic, Social and Cultural rights. It includes the requirement that, within a country, health facilities, services and goods must be available in sufficient quantity, be accessible (including affordable) to everyone without discrimination, be culturally acceptable (e.g. respectful of medical ethics and sensitive to gender and culture) and be of good quality. The right to health also includes the underlying preconditions of health: an adequate supply of safe food, nutrition and housing, access to safe and drinkable water and adequate sanitation, safe and healthy working conditions, and access to health-related education and information. Moreover, the right to health embraces a wide variety of socio-economic factors indispensable to the achievement of health. It contains freedoms, such as the right to be free from non-consensual medical treatment and to be free from forced sterilization and discrimination, as well as entitlements, such as the right to a system of health...
Another important aspect is the participation of the population in all health-related decision-making at the community, national and international levels, including migrants.

Regional instruments have also proclaimed explicitly the right to health or they offer indirect protections through other health-related rights. Instruments in the African region include the African (Banjul) Charter on Human and Peoples’ Rights, Article 16, and the African Charter on the Rights and Welfare of the Child, Article 14. In the American region there are the American Declaration on the Rights and Duties of Man, the American Convention on Human Rights, and the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women. The European region includes the European Social Charter of 1991 and revised in 1996, Article 11, and the European Convention for the Protection of Human Rights and Fundamental Freedoms and its protocols.29

Many national constitutions and statutes recognize the right to health directly or indirectly.30

The relationship between health and other human rights

The right to health has a symbiotic relationship with many other rights, including human dignity, life, the prohibition of torture, privacy, access to information, and the freedoms of association, assembly and movement. The enjoyment of the right to health in practice can positively impact on the realization of the above listed rights. Recognizing this, the African Commission on Human and Peoples’ Rights has held that “enjoyment of the human right to health as it is widely known is vital to all aspects of a person’s life and well-being, and is crucial to the realization of all the other fundamental human rights and freedoms”.31 Conversely, the failure to protect human rights can have adverse consequences for health.

Legal obligations

From a human rights perspective, states have to comply with the treaties’ legal obligations to take concrete steps to the maximum of their available resources to ensure that all persons within their jurisdiction, including migrants, receive health care and also the underlying preconditions for health.

The aforementioned General Comment No. 14 on the right to health stipulates that one aspect of the obligation to respect the right to health is to refrain from denying or restricting the equal access of irregular migrants to preventive, curative and palliative health services.32

Yet while international human rights law places on states the responsibility to ensure that facilities, goods and services required for the enjoyment of economic, social and cultural rights, like to right to health, are available to all at affordable prices, it does not stipulate that services must be provided free of charge in all cases. Subsidized or free services should be provided in those circumstances where the enjoyment of human rights is at risk, and access to social security should have the aim of preventing people from living in desperate circumstances.33

Core obligations, such as non-discrimination, are subject to neither progressive realization nor resource availability."34

Governments have an obligation to protect individuals from the actions or omissions of third parties (for example non-state stakeholders, relatives or partners) that may have an impact on the right to health and other health-related human rights (e.g. do not discriminate).

Social security

In addition, compliance with a rights based approach to health care for migrants requires social safety nets based on legislation. Accordingly, the Committee on Economic, Social and Cultural Rights General Comment No. 19 asserts the particular rights of migrant workers in respect to the right to social security, of which health care is an element.35 The Committee states that non-
nationals should be able to access non-contributory schemes for income support, affordable health care and family support. The Committee has made it clear that all non-nationals, regardless of their migration status, are entitled to primary and emergency health care. Social security schemes take a variety of forms. Under contributory social security schemes covering both nationals and non-nationals, employers of migrant workers are required by law to contribute towards social security benefits for the worker, including health care for the worker and dependants. In other cases, countries have reached mutual agreements on the portability of social security benefits between countries partly to encourage the return of migrants to their home countries on retirement as well as to assure care when migrants travel back to their homes to visit family and friends. Some countries with high dependency on migrant labour but without social health insurance schemes, such as the oil producing countries, are now developing contributory social security schemes, covering health care and disability for the salaried workers. However, these schemes rarely cover the migrants’ dependents.

The success of any social security scheme depends both upon employers’ compliance and upon workers’ knowledge of their rights. Furthermore, the process will fail to provide regular rather than ad hoc protection unless comprehensive legislative and policy developments clearly define the statutory extent of coverage, eligibility, governance and financing for all categories of migrant populations.

Protection mechanisms
States’ compliance with treaty obligations is monitored by the United Nations Treaty Monitoring Bodies. The Treaty Monitoring Bodies’ concluding observations on states’ reports cover the topic of non-nationals’ access to health services. They also argue for the application of relevant treaty provisions to irregular migrants. They have, for example, urged some States parties to take necessary legal and policy measures to ensure that irregular migrants and asylum seekers whose asylum applications have been rejected are provided with access to social security, health care and education.

Other international protection mechanisms are known as “special procedures”. They are mechanisms established by the Commission on Human Rights and assumed by the Human Rights Council to address thematic issues such as the right to health or the human rights of migrants. For example, the mission to Sweden by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health in 2006 and the subsequent report have augmented an existing movement advocating for irregular migrants’ exercise of their right to health and pursuing relevant initiatives.

Regional bodies and courts are increasingly dealing with economic, social and cultural rights, including the right to health, often shedding light on the scope of these rights and playing an important role in their protection. For example, it appears from the European Court of Human Rights’ case law that the denial of health care to irregular migrants may amount to an infringement of Article 3 (the right to be free from torture and degrading and inhuman treatment) of the abovementioned European Convention for the Protection of Human Rights and Fundamental Freedoms. Additionally, according to the Case Law of the Court, a state’s failure to provide effective access to health care for migrants in an irregular situation may also result in a violation of Articles 2 (right to life) and/or Article 8 (right to respect for private and family life).

National courts are a critical means of ensuring that the state respects the human right to health. Administrative and political mechanisms complement judicial mechanisms of accountability.
States’ Responsibilities and Other Stakeholders’ Roles Throughout the Migration Process

The following section will examine the roles and responsibilities of states and other stakeholders in ensuring migrants’ right to health at each stage of the migration process: entry, detention, stay in the country of destination, and eventual return.

Entry

Non-nationals have no general recognized right to enter another country. However, when states exercise their sovereign powers to deny admission or exclude migrants, they must do so in a manner consistent with international law, including the principle of non-discrimination. This principle requires states not to treat persons intending to enter or reside on their territory differently solely due to their health status unless there is an objective and reasonable basis for doing so.

Progress and challenges

One of the challenges in this area occurs at the interface of migration and public health. In rare situations health threats and risks to others may justify limits to personal autonomy, privacy and freedom. Examples include processes to mitigate the spread or extension of diseases of great international public health importance such as highly pathogenic infections at risk of causing serious mortality or morbidity (i.e. extremely drug resistant tuberculosis or highly pathogenic avian influenza capable of human infection). Migrants can be affected by these processes because of exposure related to their status, work or detention or because they may be subject to immigration-associated medical assessment or screening. Ensuring that restrictions based on public health rationales are empirical, equitable and justifiable is crucially important for compliance with international law in these situations.

Progress has been made. For example, with effect from January 2010, the United States lifted the ban on travel and immigration by people living with HIV. The Mexican Federal Constitution explicitly prohibits discrimination on the basis of state of health (Article 1), which is reiterated in the Federal Prevention and Elimination of Discrimination Act (Article 4). Accordingly, HIV/AIDS detection standards cannot be used for purposes other than health protection (6.3.2), including for determining entry into and departure from the country for both nationals and foreigners (6.3.4) unless such a measure is in the national interest (General Population Act Article 38). Similarly, Lesotho’s immigration laws and policies do not discriminate against entry of migrants living with HIV. Continuing this progress, the Joint United Nations Programme on HIV/AIDS (UNAIDS) set up an international task team to heighten attention to the issue of the so called HIV-related travel restrictions on international and national agendas and move towards their elimination.

Discriminatory legislation and/or practices still exist in many countries. Many countries justify such a differentiation on the grounds of protecting public health and avoiding excessive pressure on national health care resources. Indeed, various regulations are imposed with the purpose of preventing the entry or residence of migrating persons with certain diseases or conditions. However, it is questionable whether these justifications are objective, empirical and reasonable in all cases. For instance, the refusal to admit persons living with HIV on the grounds of preventing or mitigating the spread of the disease, is not a reasonable means of controlling the virus, since the virus is spread by specific behaviours rather than the mere presence of carriers and since the virus already is present in virtually every country.

Some of the policies related to migrant health can be associated with significant ethical and moral issues that extend beyond health and disease. These include the pregnancy screening of
temporary female migrant workers to prevent the birth of children during the period of employment and the use of genetic technology to determine family relationships for immigration purposes.

Recommended directions
In order to conform with international human rights law, entry as well as residence restrictions based on health status should be applied on an individual basis, taking into account the real effect of excluding the applicant on public health grounds and the cost treatment would impose on the host state.

Detention
Policies that governments use to deal with those found to have entered illegally, not having correct documentation to stay or pending deportation can have significant implications on migrants’ health. Detention, either as a deterrent or control mechanism, can be associated with several adverse health outcomes, particularly for the already vulnerable. Psychological distress and despair, including deliberate self harm have been documented. Prolonged and indefinite detention can lead to negative psychological results. The health needs of migrant detainees may often not be adequately appreciated, monitored or met, and detention itself can be profoundly damaging for their physical and mental health.

Progress and challenges
Alternative measures to detention have been successfully used by some countries. “In Slovenia, foreigners who are caught for the first time in an irregular status, or for whom there is no risk of absconding, are usually treated in open community centres where they are free to leave during the day.” In Italy, the detention of unaccompanied foreign minors is prohibited by law.

Alternatives to detention are not ubiquitous, however, and where migrants are detained, international standards ensuring their right to health should apply.

Recommended directions
As the former United Nations Special Rapporteur on the human rights of migrants recommended, infractions of immigration laws and regulations should not be considered criminal offences under national legislation. Governments should consider the possibility of progressively abolishing all forms of administrative detention. When migrants are detained, international standards should apply to help ensure that they are held in centres specifically designed for that purpose and in conditions which do not violate their human rights, including their right to health. Sufficient provision of health services and hygienic conditions, as well as adequate safety and security, are essential for the right to health of all detainees.

Stay
Barriers impeding access to health services, facilities or goods for migrants, in particular those in irregular situations, exist in a variety of forms and are practiced in many states. These include health providers’ and migrants’ lack of information regarding legislative measures concerning access by migrants, ambiguously or imprecisely defined entitlements, inappropriate implementation measures and insufficient funding, time-consuming administrative reimbursement procedures, any requirement on health service providers to report to the authorities the presence of irregular migrants, illiteracy, language problems or lengthy and complex application processes to obtain regular access to health care.
Policy and Legal Frameworks Affecting Migrants’ Health

Progress and challenges

Access to health care

Some governments have developed and adopted a variety of policies and legislative approaches to meet the health needs of migrants and to comply with their legal obligations.

In Spain, for example, municipalities, health departments, non-governmental organizations (NGOs) and trade unions, have established systems to guarantee and facilitate migrants’ access to the health care system.\(^\text{52}\)

In Italy, under Article 34 “Health Care Assistance for the foreigners registered to the National Health Care Service” of the legislative decree n.286 of 25 July 1998, foreigners have the obligation to register with the National Health Care Service, after which they are granted equal treatment and have the same rights and duties as any other Italian citizen. Health assistance is also granted to minor dependents living in Italy regardless of legal status. Children of foreigners registered with the National Health Care Service are entitled from birth to the same treatment conferred on any other Italian minor. Under Article 35 “Health Care Assistance for the foreigners not registered with the National Health Care Service” of the same decree, irregular migrants are entitled to urgent out-patient and hospital treatment or any other basic urgent treatments, even including long hospitalizations health cares, for disease and accidental injuries as well as protocol of preventive medicine to safeguard the individual and collective health. Preventive,\(^\text{54}\) necessary\(^\text{55}\) and urgent\(^\text{56}\) treatments are expressly defined by law. Even when entitlements are clearly specified by law, wide access may be impeded by lack of awareness about rights.\(^\text{57}\)

In Italy ensuring access to health services by migrants, regardless of their status, has produced important public health successes, in particular with respect to communicable diseases. For instance, Italy has observed among migrant populations reduced rates of AIDS since the introduction of highly effective antiretroviral therapy (1996); the stabilization of those infected with tuberculosis; and reduction of adverse outcomes in maternal and child health (e.g. low birth weight, perinatal and neonatal mortality).

The Committee on the Rights of the Child that monitors the implementation of the eponymous convention noted with appreciation an initiative of Malaysia to provide all children of migrant workers with unrestricted access to health services.\(^\text{58}\)

The Bahamas and Guyana provide universal access to health care with respect to HIV.\(^\text{59}\)

In Canada, where health care delivery is a provincial responsibility, costs for health care for migrants not yet eligible for health insurance are paid for by a national programme.\(^\text{60}\) The programme, administered by the Canadian immigration department, provides benefits for refugee claimants, resettled refugees, persons detained under immigration legislation, victims of trafficking in persons and the in-Canada dependants of these groups who are unable to pay for health care. Benefits are provided until the eligible migrants obtain provincial/territorial or private health plan coverage.

Although good practices exist, there is a tendency in some countries to restrict irregular migrants’ entitlements to access health care and to look at health as an instrument serving immigration control purposes rather as a human right to protect.\(^\text{61}\)

Additionally, barriers to access are faced by regular migrants. For instance, documented migrant workers in the Republic of Korea are able to independently subscribe to the National Health Insurance or to obtain subsidized corporate insurance through their employers. However, most migrants cannot afford the independent subscription, and most employers lack the economic incentives to provide subsidized insurance, since it is not compulsory. Finally, many
documented migrant workers become undocumented after changing jobs more than three times, the maximum allowed; they are then ineligible for the National Health Insurance.

**Occupational health**
Protection of the health and safety of migrant workers is critical. They have been explicitly identified as a vulnerable group. ILO standards, as aforementioned, extensively cover occupational safety and health. The International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, together with the ILO Migration for Employment Convention, 1949 (C-97) and the ILO Migrant Workers (Supplementary Provisions) Convention, 1975 (C-143), offer the most comprehensive legal framework for defining national and international migration policy and apply to all stages of the migration process, including preparation for migration, departure, transit and the period of stay and employment in the states of destination as well as return to the country of origin. Adopted 20 years ago, the Convention suffers from a relatively low level of ratification, especially in countries of destination. Still, the number of State parties is steadily growing, reaching 42 as of today. An additional 16 states have signed but not yet ratified the Convention.

**Emergency care**
It should be emphasized at the outset that mere commitment to emergency care is not legally permissible nor justified and reasonable from a public health perspective. From a legal perspective, the principle of non-discrimination proscribes, “any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement… which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health.” Thus, if non-migrants are granted health care beyond emergency care, it impermissibly discriminates against migrants to provide to them only emergency care. From a public health perspective, the failure to receive any type of preventive and primary care could create health risks for migrants and host communities. Additionally, the economic and social burden of non-access is ultimately greater than providing migrants, including irregular migrants, with access to all health services, while the benefits – both intangible and financial – contributed by migrants more than offset their use of health care.

**Health beyond nationality**
Even after acquiring the nationality of the country of destination, migrants and subsequent generations may still experience barriers to realizing their right to health. Also, some biological and genetic determinants of health, as well as certain behaviourally influenced determinants, may extend over generations. In this context, monitoring and studying the health implications and consequences of migration require a focus that goes beyond the legal boundaries of nationality and residence.

**Recommended directions**
In the context of health, successful integration in the receiving country requires, inter alia, a comprehensive interpretation of migration health beyond infectious disease control. It should encourage preventive and curative efforts in a holistic approach to health that involves migrants’ working and living in healthy conditions. Health services, goods and facilities should be provided for migrating persons’ well-being and the fulfilment of their right to health, and for the health and wealth of affected communities.

Ensuring that the right to health for all, including migrants, is formally recognized in national laws and that it is realized in practice is fundamental for its operation for those staying or residing in a given country. This can be achieved by defining entitlements; using appropriate implementation measures and sufficient funding; improving the scope and function of the existent public reimbursement schemes; eliminating requirements on health service providers to report to the authorities the presence of irregular migrants; and guaranteeing health care is
appropriate to the needs and circumstances of individual victims of trafficking in persons regardless of their willingness to cooperate in criminal proceedings against traffickers.

Finally, it is essential to ensure that everyone, from migrants to health care providers to policy-makers, is aware of the right to health, the needs of migrants, and the resources available to them. Migrants must be made aware of and gain confidence in the health care systems of Member States as well as realizing the importance of preventive health care. Migrants should participate in health services delivery, policy design, program planning and evaluation, and the health workforce should be trained about issues related to migration health. Also, researchers, policy-makers, and those involved in social and economic planning on migration health should have their awareness raised.

Return

Finally, the return of migrating persons to their country of origin may entail returning to an area with higher disease prevalence than the country where the migrant resided. The migrants’ return could also entail the introduction of health conditions acquired during the migration process into the community of origin. For instance, data suggest that Haitian migrants were infected with HIV after their arrival in the Dominican Republic.

Progress and challenges

Return conditions, as with entry and residence conditions, must not breach international law. For example, persons with life-threatening medical conditions who cannot continue with their treatment in their country of origin may not, at the risk of hastening death in distressing circumstances and thus causing inhumane treatment, be returned. In some locations, health status has, in fact, been considered a possible ground to limit sovereign power to expel a non-national.

Assisting voluntary return and reintegration of people living with HIV or with other health conditions requiring treatment and support may be particularly problematic if specific conditions are not met. Recently, a report on the situation faced by a group of migrants living with HIV in the Netherlands evaluated conditions for sustainable return and reintegration and listed the following conditions as minimum ones: the necessary medical treatment is available and accessible; the returnee can acquire an income that is sufficient to cover regular expenses for her/him and the family and to cover all costs related to medical treatment in the country of return; the returnee finds a place with a supportive social network and has the ability to cope with possible stigma from society as a whole. The report concludes that such conditions can be assessed only by taking into consideration the individual’s specific situation and the context in which she or he would return.

Finally, acquired conditions may become exposed long after return due to the latent period between occupational exposure and disease outcomes. Migrant workers can be exposed to hazardous chemicals or carcinogens at the workplace in the hosting country, and the symptoms of chronic poisoning or occupational cancer may develop after they return to their home country. For example, workers exposed to asbestos in construction sites of the hosting country in their thirties may develop lung cancer and mesothelioma in their sixties after returning to their country of origin.

Recommended directions

A case-by-case consideration of factors such as the availability and the physical and economic accessibility of treatment in the country of origin, as well as the presence of family or other support, must be taken into account in order to determine the legality of expulsion.
The country of origin should protect, respect and fulfil the right to health for all those in its territory and under its jurisdiction, including returnees.

The Role of International Organizations

As states have the primary responsibility in protecting, respecting and fulfilling the right to health for all, the involvement of international actors is only of a subsidiary nature. International actors will only engage in assistance measures related to the right to health, where states have not fully implemented the right to health. The ultimate aim of any international assistance programme is, in fact, building the capacity of the government to secure the enjoyment of the right to health by all individuals on their territory or under their jurisdiction. Nevertheless, such efforts to develop the capacity of governments or non-governmental organizations do not preclude international actors, including WHO and the International Organization for Migration (IOM), from assisting in the health sector.

Concerted Global Efforts Towards Policy Change

The growing global interest in and appreciation of the need to reorient policies in the migrant health domain can be illustrated by various recent health related UN initiatives of global importance. For instance, the United National General Assembly Special Session on HIV/AIDS (UNGASS) in 2001 called for developing and beginning by 2005 national, regional and international strategies that facilitate access to HIV/AIDS prevention programmes for migrants and mobile workers, including the provision of information on health and social services. In June 2009, following a thematic segment on “People on the move–forced displacement and migrant populations”, the UNAIDS Programme Coordination Board requested the UNAIDS Secretariat and Cosponsors: to ensure that staff at global, regional and national levels facilitate the incorporation of mobile populations, including migrants and forcibly displaced persons, into regional and national AIDS strategies to achieve universal access to prevention, treatment, care and support services.

Relevant World Health Assembly (WHA) Resolutions have addressed or included migrants’ health considerations in recent years. For instance, WHA60.26 on “Workers health, global plan of action”, urges Member States, among others, to work towards full coverage of all workers, including those in the informal economy, small- and medium-sized enterprises, agriculture, and migrant and contractual workers, with essential interventions and basic occupational health services for primary prevention of occupational and work-related diseases and injuries; WHA 61.17 on “Health of migrants”, asks Member States for migrant sensitive health policies and practices, and requests WHO to promote migrant health in collaboration with other relevant organizations, and encourages interregional and international cooperation and dialogue; WHA 62.12 on “Primary health care, including health system strengthening”, strongly reaffirms the values and principles of primary health care, including equity, solidarity, social justice, universal access to services, multisectoral action, decentralization and community participation as the basis for strengthening health systems; WHA 62.14 on “Reducing health inequities through action on the social determinants of health” urges Member States, among others, to tackle the health inequities within and across countries; and WHA62.15 on “Prevention and control of multi drug resistant tuberculosis and extensively drug resistant tuberculosis”, stresses the needs of vulnerable groups, such migrants, as well as the underlying social determinants of tuberculosis.
Conclusions

Considerations to reach policy coherence:
- Human rights based approach
- Equality and non-discrimination
- Active and informed participation of involved individuals and communities
- Sustained focus on the most vulnerable and marginalized in society, including irregular migrants
- Existence and effectiveness of accountability mechanisms
- Coordination and harmonization between countries of origin, transit and destination, as well as between relevant sectors
- Social protection, including health financing
- Broad spectrum of health issues, beyond infectious problems
- Awareness raising on “right to health” issues among all relevant stakeholders

Addressing migrant health is a necessary precondition to full realization of the benefits of migration for those who migrate and for both countries of origin and destination. “Sick people are more likely to become poor, and the poor are more vulnerable to disease and disability. Good health is central to creating the capabilities that the poor need to escape from poverty. In other words, good health is not just an outcome of development – it is a way of achieving development. The right to health has a vital role to play in tackling poverty and achieving development – it lies at the heart of our struggle for a fairer, more humane world.”

Migrant health is closely linked with the unequal distribution of socio-economic determinants including income status, housing, education, nutrition, employment. As a consequence, policy responses will be more effective if they reflect the multi-disciplinary nature of the topic and involve stakeholders from all relevant sectors. For instance, in 2007 the European Union (EU) Conference on Health and Migration in the EU: Better Health for All in an Inclusive Society, stressed the need for coherent immigration policies that incorporate health dimensions at EU and country level and promoted a “health in all policies” approach to migrant health. Such an approach could help avoid the development of contradicting policies and legislation within one country.

Not only should policies and strategies to address migrant health be multi-sectoral in nature, they also require multilateral cooperation and coordination among the communities or countries involved in the migration process. Migrants, by default connect communities or countries and their respective health environments. Harmonization of policies among countries is required to support the health of migrants and hosting communities throughout the migration process. Especially considering today’s magnitude of circular migration flows, inter country and regional approaches facilitate uninterrupted treatment.

This paper has shown that legislative and policy frameworks that relate to the health of migrants exist at international, regional and national levels. Some have argued that providing adequate health care and ensuring the preconditions of health decreases the cost implications of addressing migrants’ health needs. The principles of health economics show that cost containment is achieved through timely and appropriate use of services, particular preventive services, and when utilization is not hampered by problems of accessibility. A human rights-based approach leads to the same end: the ultimate goal of enhancing the realization of the right to health – and other interrelated rights – requires legislative and policy development processes that consider the relationship of migration and the determinants of health. Accordingly, this paper has emphasized that there are existing legal and policy frameworks that address the issues of the accessibility of health services and the preconditions of health from the point of view of
migrants’ right to health. Consider, in light of the recommendations provided, whether the existing frameworks are effective and what can be done to strengthen their support of migrants’ right to health.


8 “Dissociation between nationality and physical presence has many consequences. As strangers to a society, migrants may be unfamiliar with the national language, laws and practice, and less able than others to know and assert their rights. They may face discrimination, and be subjected to unequal treatment and unequal opportunities at work, and in their daily lives. They may also face racism and xenophobia.” Council of Europe, The Human Rights of Irregular Migrants in Europe, CommDH/IssuePaper1.

9 See note 4.

10 Occupational health and safety among migrants is essential as studies show a large proportion of all reported occupational diseases and accidents occur among migrating persons. Low-skilled migrants as well as irregular migrants are at a high risk of being victims of occupational accident while working in high risk jobs with poor supervision. This is the case for migrants working in mining, construction, heavy manufacturing and agriculture. In the agriculture sector, for example, chronic and unprotected exposure to pesticides and other chemical products is associated with high incidence of depression,


16 Data disaggregation can identify discrimination on prohibited grounds, such as race, ethnicity, gender, age, nationality and migration status, and is therefore essential for public policy design. For discussion of migration status as a protected status based on prohibition of discrimination based on “other status”, see Cholewinski R. Migrant workers in international human rights law: their protection in countries of employment. Oxford, Clarendon Press, 1997. in particular Chapters 3 and 4; and Cholewinski, R. Borders and discrimination in the European Union. Brussels, Immigration Law Practitioners’ Association and Migration Policy Group, 2002, Chapter 3.


18 Idem.

19 The ILO claims that its SAFEWORK unit has jurisdiction for over seventy Conventions and Recommendations pertaining to occupational safety and health. These topics range from subjects as diverse as maternity protection (1919) to maritime, workers’ compensation, asbestos, benzene, and C 155 the Convention whereby member governments undertake to create regulatory frameworks to protect safety and health in the workplace. Additional Conventions and Recommendations concern safety and health or hygiene in specific branches of activity such as construction, mines, agriculture, commerce and offices.

20 Convention No. 97 of 1949 concerning Migration for Employment; Recommendation No. 86 concerning Migration for Employment (Revised 1949); Convention No. 143 of 1975 concerning Migrations in Abusive Conditions and the Promotion of Equality of Opportunity and Treatment of Migrant Workers; and Recommendation of 1975, No. 151 concerning Migrant Workers.

21 As of 11 February 2010, the Covenant has been ratified or acceded to by 160 States.

22 As of 11 February 2010, the Convention has been ratified or acceded to by 173 States.

23 As of 11 February 2010, the Convention has been ratified or acceded to by all States except for two.

24 As of 11 February 2010, the Convention has been ratified or acceded to by 186 States.

25 As of 11 February 2010, the Convention has been ratified or acceded to by 42 States (http://www.migrantsrights.org/index.htm, accessed 21 February 2010).

26 As of 11 February 2010, the Convention has been ratified or acceded to by 79 States.


28 See note 17.


34 States Parties to the International Covenant on Economic, Social and Cultural Rights with the resources to implement Article 12 of the Covenant cannot lawfully decide to refrain from taking the necessary steps to implement the said article. The States Parties with insufficient resources are, nonetheless, under an obligation of progressive realization of the right to health through the taking of concrete steps intended to fully implement the right to health, while guaranteeing that the right will be exercised without discrimination.

35 The ILO defines social security as “the protection which society provides for its members, through a series of measures, against the economic and social distress that otherwise would be caused by the stoppage or substantial reduction of earnings resulting from sickness, maternity, employment injury, unemployment, invalidity, old age and death; the provision of medical care; and the provision of subsidies for children”. ILO, 1989: 3.

36 CESCR General Comment No. 19 on the right to social security (Article 9), E/C.12/GC/19, 4 February 2008.

37 Kulke U. *The role of social security in protecting migrant workers: the ILO approach*. International Social Security Association, ISSA Regional Conference for Asia and the Pacific, 2006. The Philippines are an example of a country that has made progress in meeting these goals. Agreements have been signed with many countries providing equality of treatment, export of benefits, accumulation of membership periods, and mutual administrative assistance. In addition, the Social Security System of the Philippines offers “Overseas Foreign Workers” coverage of family members remaining at home. ILO, *Social Protection Expenditure and Coverage Review of the Philippines*, ILO Subregional Office for South East Asia, Bangkok, 2008.


39 The Special Rapporteurs on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and on the human rights of migrants and the Working Group on Arbitrary Detention. Relevant are also the mandates of the Special Rapporteurs on the right to food; on the right to adequate housing as a component of the right to an adequate standard of living; on the right to education; on trafficking in persons, especially women and girls; on violence against women, its causes and consequences; on the sale of children, child prostitution and child pornography; and on torture and other cruel, inhuman or degrading treatment or punishment.

40 See note 70.


50 With respect to children, see Annual Thematic Report to the Human Rights Council, A/HRC/11/7; and Annual Report to the General Assembly A/64/213.

51 See 1990 UN Rules for the Protection of Juveniles Deprived of their Liberty; the 1990 Basic Principles for the Treatment of Prisoners and the 1988 Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment.


54 Preventive care includes treatment aiming to safeguard individual and collective health such as pregnancy and maternity care; full health care for everyone under 18; vaccinations; prophylaxis, diagnosis and treatment of infectious diseases; prevention, treatment and rehabilitation of toxic dependencies; international preventive measures.

55 Necessary treatment includes medical assistance, medical check-ups, treatment for conditions which are non-dangerous in the immediate/short run, but that, if left untreated, will cause major harm to the health of the person or put his/her life at risk.

56 Urgent treatment is treatment which cannot be deferred without putting into danger the patient’s health or life.

57 See Hughes J, and. Foschia JP. eds. *Migrant-friendly health services and hiv/sti prevention: a handbook for practitioners, managers and policy planners*, published by the Veneto Regional Centre for Health Promotion (CRRPS), Verona, Italy, with financial assistance from the European Commission, November 2004. In 2004, Médécins Sans Frontières visited and interviewed 770 seasonal farm workers in Italy, 51.4% of whom were in an irregular situation and 23.4% of whom were asylum-seekers. 40% had become ill during their first 6 months in Italy and 93% after 19 months. The most common problems were: infectious diseases, skin problems, intestinal parasites, and mouth, throat, and respiratory infections including tuberculosis. However, 75% of the refugees, 85.3%
of asylum-seekers, and 88.6% of irregular migrants were not benefiting from any health care. This resulted from unawareness of their rights. Médecins Sans Frontières Italy. The fruits of hypocrisy: history of who makes the agriculture...hidden, Rome, 2005.

59 IOM. Migration and HIV in the Caribbean. Legal and Political Response. forthcoming.
63 See note 19.
65 See Romero-Ortuño R. Access to health care for illegal immigrants in the EU: should we be concerned? In European Journal of Health Law, 2004, 11:252–53. Romero-Ortuño also argues that, at the very least, the accessibility of healthcare does not appear to be a pull factor.
67 “Migration and health of migrants”. IOM contribution to Resolution EUR/RC52/R7 case studies: how European health systems are addressing the health of socioeconomically disadvantaged groups [TBC]. Copenhagen, WHO Regional Office for Europe, forthcoming.
68 See note 17.
69 See note 59.
73 Opening remarks of Paul Hunt, UN Special Rapporteur on the Right to the Highest Attainable Standard of Health to the London launch of the ‘call to action’ on the right to health, 9 December 2005.